Immigrant women's perceptions and experiences of health care services: insights from a focus group study

Dias, Sónia; Gama, Ana; Rocha, Cristianne

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Corresponding Author: Prof. Sónia Dias,

Corresponding Author's Institution:

First Author: Sónia Dias, PhD

Order of Authors: Sónia Dias, PhD; Sónia Dias; Ana Gama, MsD; Cristianne Rocha, EdD

Abstract: Aim: This study aimed to describe perceptions and experiences related to access and utilization of health care services of African and Brazilian immigrant women in Portugal.
Subject and Methods: Six focus groups were conducted with 35 African and Brazilian women with low income and living in Lisbon, chosen through purposive sampling. Content analysis was undertaken through identification of themes and categories.
Results: African and Brazilian women expressed different perceptions and patterns of use of health care services. Most participants pointed out several barriers in access and utilization of services related to legal issues, economic constraints or health professionals' attitudes.
Conclusion: These results highlight the challenges for providing health care within a multicultural setting and the need of assuring integrated and comprehensive health care services. Improving access to general health care is essential to minimising disadvantage from vulnerable subgroups, like immigrant women. Supporting better integration into the health system may lead to greater health outcomes.

Response to Reviewers: See attachment.

Dear Editor,

Thank you very much for considering to accept, after revision, our manuscript named **Immigrant women's perceptions and experiences of health care services: Insights from a Focus Group Study**. We are grateful for the comments provided by the reviewers; we believe that these improved very much our new version of the manuscript and further clarified our thinking in this issue. We went through every comment and here we present our review of the previous version, indicating the changes proposed.

Abstract
Regarding the suggestion *"page 1, line 31: "most participants pointed…" (…) it should be better to use the word "or" ["... legal issues, economic constraints, or health professionals attitudes."],* we changed the sentence as proposed by the reviewer.

Introduction
We recognize the importance of adding some general information about the situation of immigration in Portugal. Therefore, we added in the Introduction section a description of the proportion of immigrants and immigrant women in Portugal. Also, to better clarify the choice of including in this study the two target groups, we referred that the most representative immigrant women groups in Portugal are from Brazil and Portuguese-speaking African countries. As regards the specific countries of origin of African participants, we added this information in the section of Socio-demographic characteristics of participants.

Taking into account the comments of the reviewers, we added a description of the Portuguese policy and rights regarding access to health services. We agree that such information certainly may be helpful for readers from outside Portugal.

We clarified the contribution of gender and migrant status to understanding differences in vulnerability to health and access to health care. Simultaneously, we took into account the comment of one reviewer who considered that in page 3, line 14, *"this part is redundant"*. So we revised this sentence. As suggested, references of quantitative data on access and utilization of health care services of immigrants in Portugal were added.

Methods and participants
We revised the Methods and participants section and, as one reviewer proposed, described in more detail the sampling and mode of analysis of data. For better clarification of the procedure, we explained that in collaboration with the research team, several non governmental organizations, associations and social institutions working with immigrant communities identified potential participants according to the inclusion criteria (being from Brazil or Portuguese-speaking African countries, being 18-45 years old and residing in Portugal for at least two years). Afterward, the research team contacted these women in order to invite them to participate, to confirm inclusion criteria, to present briefly the project and to inform about logistics of focus groups (location, time, etc.). Women participated in the study according to their availability and interest to participate. In order to ensure the participation in focus groups, several telephone contacts were made to each participant, with a last contact made in the day before the session. [This information was added in the manuscript].The focus groups were conducted with the participants who attended to the group sessions. Indeed, as one

of the reviewers underlined, each of the 3 groups with African participants comprised 6 or 7 women, and each of the 3 groups with Brazilian participants included 5 women.

As proposed by one reviewer, we revised the text and specified that informed consent was obtained before group discussions, in page 5 line 7.

We do agree that it would be interesting to have information about the religion of participants but unfortunately we did not collect data on this. Due to the sensitive nature of religion-related questions we avoided exploring this issue in the focus groups as it is often considered intrusive.

In relation to comment *"Page 5, line 55: "Discussions .... between groups were compared ...." Have there been any discussion between the groups (e. g. between African and Brazilian immigrant groups)??*, in fact there was no discussion between the groups; we conducted 6 focus groups (3 with African women and 3 with Brazilian women). In order to clarify the sentence in the manuscript, we revised it explaining that firstly analyses focused on each focus group separately and then on the comparison between Brazilian and African groups.

Results

The topic about "alternative medicine" was only slightly mentioned by participants in the focus groups and we did not explore this in the sessions. So unfortunately it is not possible to clarify such issues in this study as we did not collect information on what kind of alternative medicine women were referring to. Although, it would be very interesting to develop further research to better understand the use of alternative medicine by women.

"Page 11, line 51 - 53: ". male health professionals have misinterpreted an offered gesture of gratitude." What does it mean exactly? Do You mean sexual trouble??". Indeed, in group sessions several Brazilian women described episodes of sexual discrimination experienced in Portugal, besides color-based discrimination.

As the reviewer pointed out (*"Page 12, line 31"*) the sentence was said by an African woman and not by a Brazilian, as mistakenly written. Thus it was amended in the manuscript.

Discussion

Agreeing with the reviewers' comments that *"Many of the findings could also be true for the host population in Portugal"*, we look in the scarce literature in Portugal about this topic and, in fact, the few studies conducted in Portugal with general population show similar constraints, namely the complex procedures to make an appointment and the long waiting time (Santos et al. 2007; Cabral et al. 2002). However, the findings of our study suggest that these issues may have particular impact for immigrant women as they frequently have poorer labour protection. In fact, participants stated that they have full-time jobs with inflexible working hours and it is impossible for them to take a day off from work. [This information was added in the manuscript].

In respect to the note *"Of course quantitative representativeness cannot be achieved in a study that aims to explore perceptions. Therefore a representative study for the general immigrant population would not only be difficult to carry out but also would*

not serve the same purpose", we are totally in agreement with the reviewer. What we meant was that our findings cannot be generalized once a purposive sampling was used, but this, as the reviewer highlighted, is a characteristic of qualitative methodology. Therefore we considered to remove the sentence in page 16.

We completely agree with the reviewer (*"Diversity management and cultural sensitivity are parts of the solution. But is an increasing of the utilization of the health system a solution (page 17, line 12)?*). Our results show that promotion of access and utilization of health care services is important; however further efforts in other areas are needed, like the promotion of cultural sensitivity and competence of health professionals.

We changed the text according to the reviewers' suggestions: we removed the extra spaces and the dot; we checked and changed the reference (indeed the author name in both cases is Geiger HJ); in Page 22, line 31 (*" disparities in access."*) we corrected the sentence and wrote "in" instead of "en"; and revised pages 8 and 15 for grammatical and vocabulary improvement.

Yours sincerely,

Sónia Dias

*Title Page

Immigrant women´s perceptions and experiences of health care services: Insights from a Focus Group Study

Sónia Dias*, Ana Gama** & Cristianne Rocha***

* PhD, Institute of Hygiene and Tropical Medicine, New University of Lisbon, Lisbon, Portugal.

** MsD, Institute of Hygiene and Tropical Medicine, New University of Lisbon, Lisbon, Portugal.

*** EdD, Brazil Lutheran University, Porto Alegre, Brazil

Corresponding Author:

Sónia Dias

Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa

Rua da Junqueira, 96

1349-008 Lisboa

Portugal

Tel: 00 351 21 3652600

Fax: 00 351 21 3632105

e-mail: sfdias@ihmt.unl.pt, smfdias@yahoo.com

Ana Gama

Instituto de Higiene e Medicina Tropical

Universidade Nova de Lisboa

Rua da Junqueira, 96

1349-008 Lisboa

Portugal

Tel: 00 351 21 3652600

Fax: 00 351 21 3632105

e-mail: anafgama@gmail.com

Cristianne Rocha

Rua Irmão José Otão, 170 – Apto. 905

CEP: 90035-060 - Porto Alegre - RS

Brazil

Tel: 00 55 5132398001

Fax: 00 55 5132398001

e-mail: cristianne.rocha@terra.com.br

Immigrant women's perceptions and experiences of health care services: Insights from a Focus Group Study

Abstract

Aim: This study aimed to describe perceptions and experiences related to access and utilization of health care services of African and Brazilian immigrant women in Portugal.

Subject and Methods: Six focus groups were conducted with 35 African and Brazilian women with low income and living in Lisbon, chosen through purposive sampling. Content analysis was undertaken through identification of themes and categories.

Results: African and Brazilian women expressed different perceptions and patterns of use of health care services. Most participants pointed out several barriers in access and utilization of services related to legal issues, economic constraints or health professionals' attitudes.

Conclusion: These results highlight the challenges for providing health care within a multicultural setting and the need of assuring integrated and comprehensive health care services. Improving access to general health care is essential to minimising disadvantage from vulnerable subgroups, like immigrant women. Supporting better integration into the health system may lead to greater health outcomes.

Key Words: Immigrant women, perceptions, experiences, access and utilization of health care services

Introduction

The increasing number of immigrants in Europe poses new challenges to host countries on how to achieve better social integration for these populations (Eurostat 2006).

Recent data indicates that the proportion of women migrating to Europe has growing and becoming higher than men (United Nations 2005). In Portugal, the official data indicate that among immigrants - 6.1% of the total population - 45% is female (SEF 2008). Currently, the countries of origin of the most representative immigrant women groups in Portugal are Brazil and Portuguese-speaking African countries (SEF 2008).

Female migration has been recognized as an important challenge for public health as increasing evidence points out that migration can adversely affect health of migrant women (UNFPA 2006; UNFPA/IOM 2006). When arriving in a new country, immigrants often face a different social, structural and cultural context which frequently exposes them to risk factors with impact in health status (Dias et al. 2008; Fennelly 2004). Although this applies to both men and women, analysis from a gender perspective highlights that immigrant women are more likely to be in socially disadvantaged situations as poverty, social exclusion, irregular administrative situation and poor social and labour protection, rendering them more vulnerable (Llácer et al. 2007; Pécoud and Guchteneire 2004).

Some researches report that the health risk is partly associated with limited access and utilization of health services (Politzer et al. 2001; Stronks et al. 2001). Studies indicate that in several host countries, even in those where access to health care is guaranteed, immigrant women do not regularly benefit of the health care services available and often are not covered by services for information, prevention and treatment (Fennelly 2004; Goddard and Smith 2001; Scheppers et al. 2006).

The Portuguese Constitution establishes that all citizens – including immigrants – have the right to be attended in National Health Service (NHS) and in principle, health care should be available to every person according to need, irrespective of nationality, legal status or any other criterion. According to current legislation, persons without a NHS card (those without a residency or work visa) or who do not pay social security must pay the full fare for services. However, there are some exceptions: in case of a public health threat, children under 12 years of age, pregnant women and recent mothers, users of family planning programs, unemployed registered at a job centre and their dependants, recipients of welfare benefits and individuals with legally recognized chronic diseases. Despite of the efforts undertaken, the available data indicate that migrants residing in Portugal still face difficulties in accessing and utilizing health services (Gonçalves et al. 2003; Machado et al. 2006). A recent study on health care utilization among immigrants in Portugal showed that 17.5% of female participants have never used health services (Dias et al. 2008).

Although immigrant women are more likely to utilize health care services than men due to women's longer life span and reproductive health needs (Parslow et al. 2004), they are also more likely to postpone receiving health care because usually they have fewer financial resources to pay for health care (Jatrana and Crampton 2009; Ranji et al. 2007). Other studies have reported that immigrant women often experience lower levels of education, precarious employment and irregular administrative status, which have been identified as barriers in accessing health care services (Grieco 2002; Marshall et al. 2005). In addition, gender inequalities related to social roles and cultural norms may limit women's access to health care (Lane and Cibula 2000).

In summary, a growing body of research has acknowledging that utilization of health services among immigrants is a product of a dynamic interaction between multiple factors.

The increasing proportion of immigrant women worldwide, the reported barriers in access and utilization of health care services among this group and the lack of information on these issues suggest that deeper knowledge is needed. It is important to assess women's perceptions and perceived needs concerning health care to better understand the challenges they face in accessing and using health care services. Research on access and utilization of health care services of immigrants has based mainly on quantitative data (Dias et al. 2008; Marshall et al. 2005; Stronks et al. 2001); lack of information on women's perspectives on these issues remains. Qualitative research may contribute to deeply understand immigrant women's perspectives on health care services and explore cultural differences associated with these issues (Green and Thorogood 2004).

This study aimed to describe perceptions and experiences related to access and utilization of health care services of African and Brazilian immigrant women in Portugal.

Methods and Participants

To deeply understand migrants' perspectives on health care services, a qualitative research method using focus group was chosen. Focus group is recognized as an important technique for working in a diverse cultural setting, providing rich and valuable information (Culley et al. 2007). Furthermore, synergistic effects of the group setting bring out ideas and discussion that do not arise in individual interviews (Kidd and Parshall 2000).

Sampling and recruitment

Six focus groups were conducted with 35 immigrant women with low income living in Lisbon, chosen through purposive sampling.

In collaboration with the research team, several non governmental organizations, associations and social institutions working with immigrant communities identified potential participants according to the following inclusion criteria: being from Brazil or Portuguese-speaking African countries, being 18-45 years old and residing in Portugal for at least two years. Afterward, the research team contacted these women in order to invite them to participate, to confirm inclusion criteria, to present briefly the project and to inform about logistics of focus groups (location, time, etc.). Women participated in the study according to their availability and interest to participate. In order to ensure the participation in focus groups, several telephone contacts were made to each participant, with a last contact made in the day before the session. Three focus groups were conducted with each group (African and Brazilian).

Procedure

At the beginning of each focus group session, participants were fully informed about the purpose of the project, the procedure of data collection and how discussion would be conducted. Participants were clearly told that they might choose not to participate or quit at any moment during the group session. Anonymity and confidentiality of data were guaranteed, and informed and voluntary consent was obtained.

A semi-structured topic guide was used to conduct focus group sessions, covering all relevant topics and allowing the discussion to flow naturally. Focus groups were facilitated by a member of the research team and a co-moderator acting as a non-participant observer. Each discussion was audio taped using a digital recorder to maximize data collection and help to transcribe discussions for analysis. Field notes were taken to describe emergent themes and body language of participants. Focus groups were conducted between May and June of 2008. Group discussions lasted an average of one-and-a-half hour.

After group discussions, a questionnaire was applied for participants' socio-demographic characterization; it included information about age, country of origin, nationality, immigration status, educational level, employment status and length of stay in Portugal.

The study was approved by the Ethical Committee of the Institute of Hygiene and Tropical Medicine, New University of Lisbon.

Analysis of data

All discussions were transcribed, and transcripts were verified through audiotape recordings for accuracy. Data was analyzed according to content analysis procedure commonly used in qualitative methodology (Krueger and Casey 2000; Morgan 2002). The analysis began

by reading through the transcripts and listening to the audio records, in order to identify the relevant ideas and concepts emerged in the group sessions. On the basis of the thematic topics, initial categories were created that later evolved and changed even during the analysis. Afterward, two independent investigators coded and organized data according to these categories. The opinions of participants on the different themes were analyzed taking into account the group agreements and individual contributions. Coded transcripts were reviewed and overall there was high agreement between researchers. In the few cases where agreement was not achieved, a discussion was held between all investigators to resolve inconsistencies of interpretation. Firstly, the analyses focused on each focus group separately and then on the comparison between African and Brazilian groups.

To maintain participants' confidentiality, names of individuals and institutions were not included in transcripts and all participants are referred as either women or participants in this article. Quotes were chosen to best illustrate the themes emerging from data analysis.

Results

Socio-demographic characteristics of participants

Among participants, 20 were African and 15 were Brazilian (Table 1). Among the African participants, nine were from Cape Verde, six from Angola, four from Sao Tome and Principe and one from Guinea. The mean age of African participants was 38.5 years (SD=6.8) while Brazilian participants' mean age was 30.9 years (SD=7.8).

Three African women and one Brazilian reported to have also Portuguese nationality. Among the others, 13 African women and nine Brazilian reported to have legal status. Length of stay in Portugal varied between 2 and 20 years, with most African women residing for more than 10 years in Portugal while all Brazilian women resided for less than 10 years. African participants reported lower educational level when compared to Brazilian. The great majority of participants (n=33) reported to be employed (18 African and 15 Brazilian women).

Findings of focus group discussions

The content analysis of discussions' transcripts enabled to describe attitudes and practices of participants with regard to access and utilization of health care services. The main themes emerged are highlighted below.

Patterns of use of health care services

Different patterns of health care services utilization were described throughout the focus group discussions. Several women reported to use health care services in a preventive and regular way, emphasizing the importance of medical care through regular appointments. In

contrast, some women mentioned that they only use health care services when they are ill. The use of health care services for sexual and reproductive health was also discussed by participants. Despite recognizing the importance of medical guidance, several women stated a non-regular use of health care services and uptake of clinical tests in this area. In particular African women described that they rarely attend family planning and prenatal care services: *"I don't attend family planning, I don't do that." (African participant); "I go to the doctor at four months of pregnancy." (African participant).* Other participants also reported the non use of health care services.

In the majority of focus group discussions, participants mentioned the use of different types of health care services, pointing out several reasons for their option: "*Most of the times I wait until my husband takes me to the hospital, so I can take all the exams that I need." (African participant); "The assistance at the health centre is excellent (…) however at the hospital, honestly, I'm afraid (…) they aren't so cautious." (Brazilian participant).* An interesting aspect raised by Brazilian participants was their frequent use of health care services in their country of origin, through medical appointments when they travel to Brazil during vacations or medical orientation by telephone (often, they rely on relatives to make this contact).

Comparison between provision of health care in the country of origin and in Portugal

In all focus group discussions with African women, the provision of health care in Portugal was considered more efficient than in the country of origin.

Differences between health care in the country of origin and in the host country were mainly explored in group discussions with Brazilian women. In these sessions, participants

pointed out health care strategies that are undertaken in Brazil but, according to participants, lack in Portugal: "*In Brazil the family doctor or nurse goes to our house once a month and check if everything is in order. (...) At the health centre they have a medical record of my family (...) that's what I call family medicine, and it's not what they do here." (Brazilian participant).*

Brazilian participants also discussed the lower frequency of tests, the higher prescription of medication and the lack of reliance on alternative medicine in Portugal: "*The test [Pap smear] is done every two years, but in Brazil we have to do it every six months. Here, my doctor says it is not necessary." (Brazilian participant); "In Brazil, they don't prescribe so many antibiotics as it happens here. (…) Brazil is more evolved when it comes to alternative medicine." (Brazilian participant).*

Perceptions of health care services

During discussions, several participants revealed to dislike and fear using health care services: "*I don't like to go to the doctor, I have phobia of hospitals, the smell, I don't like it, I faint instantly." (African participant).* Mostly Brazilian participants described negative experiences in health care services expressing mistrust and the perception of poor quality of the delivered health care: "*they put everyone in a large room, there isn't any privacy. Worse than having no privacy is to hear other women screaming." (Brazilian participant).* Also, for some Brazilian participants, preventive medicine is not valued in Portugal. They described that sometimes doctors criticize patients' initiative to request for tests and exams: "*When I went to the doctor and asked her for exams, she questioned everything: 'Why did you asked for blood tests? Why do you want to do a mammogram?' I don't think they should do that… I felt criticized." (Brazilian participant).*

Barriers in access and utilization of health care services

An issue frequently discussed by participants in group sessions was the existing barriers in access and utilization of health care services. In general, Brazilian participants expressed the difficulties faced in accessing health care services *"when you have no documents"*, and it was perceptible how this issue may affect the utilization of such services: *"When I was illegal (…) I had to pay for everything in private medicine." (Brazilian participant); "When you are illegal, they send you to the emergency service. It is no use going to the health centre." (Brazilian participant).* In contrast, African participants considered that immigration status had no implications in access to health care services in Portugal: *"Before my legal status, I always had a family doctor, with or without legal documents I always had a doctor for my children and for me." (African participant).*

Several women pointed out the complex procedures and the long waiting time to make medical appointments: *"it take too much time to make a medical appointment (…) you have to get a ticket, come back for the appointment, schedule the exam and then come back another day." (Brazilian participant).* Discussions revealed that for some participants having to miss work to attend a medical appointment often hinders the use of health care services. Women suggested that the working hours of the services should be extended in order to overcome time constraints: *"To attend a medical appointment, I have to miss a day of work. I have two jobs (…) so I have to compromise both." (Brazilian participant); "I don't like to miss work, even when I'm ill; if I'm able to stand up I'll go to work." (Brazilian participant); "There should be a health centre opened at least until midnight" (African participant).* Several women also expressed that the cost associated with health care often influences which services they decide to

use: *"Maybe it is better at the hospital because you pay what everyone else pays but at the health centre you have to pay over 32 Euros." (African participant).*

Another barrier pointed out as affecting women's use of health care services was the attitudes of health professionals. Several participants complained about the way they are treated by administrative staff: *"The women who work at the reception have no education; they are very rude." (Brazilian participant); "The way they treat us, sometimes they are so arrogant that I don't feel like waiting." (African participant).* In addition, women mentioned constraints in the doctor-patient relationship emphasizing the lack of attention of doctors: *"I went to the health centre (…) [the doctor] let me in, looked at the paper and didn't even look at me. I think that some attention is needed." (Brazilian participant).* Furthermore, for some participants health professionals are insensitive to the condition of being an immigrant: *"You go through many difficulties here, you may be alone and I think they don't care about that." (Brazilian participant).* During the focus group discussions, several women expressed the importance of a more sensitive approach to immigration-related issues in health care services. Participants also argued that health professionals should be trained to deal with cultural diversity and considered that such strategy could increase the utilization of health care services.

Another issue discussed mainly by Brazilian participants was related to the set of stereotypes that frequently health professionals hold with regard to Brazilian women. Participants described situations where health professionals have implied that Brazilian women have more diseases than residents and others where male health professionals have misinterpreted an offered gesture of gratitude.

During group discussions, participants mentioned that they have experienced discrimination in health care services revealing that those negative experiences often lead to an

under use or even non use of the services: *"The nurse said: 'Damn! You were so much better in your country and you came here to have your child?' That comment was very unfortunate and it was very disturbing." (Brazilian participant); "I didn't get to be attended and I went home feeling worse (…) so I have never returned there [the service]." (Brazilian participant).*

In focus group sessions, African women said that usually African immigrants do not consider the use of health care services important: "*This happens very often, Africans think that they are their own doctors." (African participant).* Through group discussions it was perceptible the influencing role of cultural factors on women's use of health care services. Several African participants mentioned that certain attitudes of their male partners concerning the use of sexual and reproductive health services often affect women's utilization of such services: "*I have a friend whose husband dislikes the fact of her going to the doctor. Machismo…to show that he is above her, that he is in charge." (African participant).* Participants also referred that misinformation about their health rights and requirements to use health care services difficult the access to these services.

Despite the negative experiences described by most participants, a small group of women considered that the barriers they face as immigrants are the same encountered by Portuguese women and reported positive experiences on health care services, emphasizing the importance of the provided social support.

Discussion

The results of this study suggest different patterns of utilization of health care services among immigrant women from using on a regular basis to not using at all, consistently with previous studies (Aroian 2005; Geiger 2006). These results highlight the challenges for providing health care within a multicultural setting and the need of assuring integrated and comprehensive health care services.

Different opinions were found among African and Brazilian women about the provision of health care in Portugal compared to the country of origin. Some explanations can be put forward to explain these results. Some authors refer that women's perspectives on the delivered health care and the degree of satisfaction with the health system are strongly influenced by their expectations of care and previous experiences in the country of origin (Gurman and Becker 2008; Sofaer and Firminger 2005). Therefore, it is possible to admit that among participants, those from countries that lack health care structures may perceive health care services in Portugal as of higher quality while others from countries with a more efficient health system may perceive those services as less competent, like previous studies suggest (Dias et al. 2008; Gurman and Becker 2008).

Participants' perceptions of health care services in Portugal were further explored in focus group discussions. Several women revealed to dislike, mistrust and fear using health care services. Other authors have reported that populations tend to mistrust a health system that is not familiar (Ingleby et al. 2005; Manfellotto 2002). Culture and ethnicity may play an important role in producing social perceptions related to health as it creates a unique pattern of beliefs about what health means that shapes how symptoms are recognized and interpreted, and affects how and when health care services are used (Anderson et al. 2003).

Barriers in access and utilization of health care services such as legal, structural, socioeconomic and related to professionals' attitudes were pointed out by participants, as in previous research (Fennelly 2004; Scheppers et al. 2006). Mainly Brazilian women considered immigration status as a key factor in access to health care services describing that frequently access to services was restricted when they were undocumented. In contrast, mostly African women considered that there are no difficulties in accessing health care services in Portugal regardless immigration status. The different opinions on this issue may be partly due to the fact that among the sample, African participants reported higher length of stay in Portugal than Brazilian women. The length of stay has been positively associated with integration in the host country and specifically with knowledge on the health system and utilization of the health services (Dias et al. 2008; Leduc and Proulx 2004). Therefore, it is possible to speculate that in our sample African participants are better informed about the health system and their rights in access to health care services (access to health care is guaranteed in Portugal). These findings also suggest the need to increase women's awareness about their entitlement to, and the benefits of health care services as misinformation about immigrants' health rights and the requirements to use health care services was perceptible among participants, as in previous research (Ingleby et al. 2005; Manfellotto 2002).

Other barriers mentioned by participants included the cost of health care services. Financial constraints may impede migrants' access to the optimal health care as migrants often have poor socioeconomic conditions than the majority population (Norredam et al. 2007). Several participants also complained about the restricted working hours of health care services, the complex procedures to make appointments and the long waiting time. It is interesting to note that such constraints have been also documented in previous studies on utilization of health care

services among Portuguese citizens (Cabral et al. 2002; Santos et al. 2007). Nevertheless, our findings suggest that these issues may differentially affect immigrant women as they often have poorer labour protection. In fact, participants stated that frequently they have full-time jobs with inflexible working hours and it is impossible for them to take a day off from work, which has been referred in other researches (Dias et al. 2008; Fennelly 2004). Indeed, participants suggested that the working hours of the services should be extended in order to overcome time constraints.

As in previous studies, several participants have identified stereotyped and discriminatory attitudes of health professionals, which include lack of sympathy, use of discriminatory language or even hostile attitudes toward immigrants (Campayo et al. 2006; Michaelsen et al. 2004). These factors have been considered as major barriers to the utilization of health care services because often result in patients' delay or refusal to seek needed care (Geiger 2001; LaVeist et al. 2000; Lillie-Blanton et al. 2000). According to previous researches, and as participants pointed out, negative attitudes of health professionals may reflect their inability to deal with cultural diversity and their lack of sensitivity about immigrants' social and cultural beliefs related to health and health care (Dawson and Gifford 2001; Kwok and Sullivan 2007). An important component of promotion of access to care for culturally diverse populations is the cultural competence of health systems. Interventions to promote such competence like training of health professionals to deal with cultural diversity should be developed to improve providers' cultural sensitivity, to help providing a welcoming health care environment for patients and therefore improve utilization of health care services and quality of care (Anderson et al. 2003; Betancourt et al. 2005).

The findings also suggest that the choices related to the utilization of health care services are mostly framed in the social context through cultural, social and family ties (Scheppers et al. 2006). Indeed, previous studies refer that cultural background has an important influence on people's health beliefs and health-related behaviour (Anderson et al. 2003; Kwok and Sullivan 2007).

Our results may have implications for future applied research on the quality of health care services. Some women expressed high levels of satisfaction with their care, yet when asked for details, they described various problems related with health care services. This phenomenon, also recognized by other researchers (Staniszewska and Henderson 2004; Williams et al. 1998), suggests that using qualitative research methods is important to study patients' experiences with care because these methods rely on listening to patients' accounts and provide more detailed information about their experiences (Avis 1997; Scrimshaw et al. 1997). Such research may benefit the health system and patients as it can lead to ideas about ways in which health care could be improved.

Our study had some limitations that should be recognized when interpreting the results. The main limitation is related with those of qualitative methodology. The group dynamic of focus groups may inhibit individual expression of opinions and experiences that are not consistent with those from the majority of participants. Despite the limitations, our study strengthens the current literature with regard to patterns of use and barriers in access and utilization of health care services among immigrant women, and relevant strategies to improve health care among these groups.

In conclusion, the ultimate goal of health care services administrators and health professionals should be to ensure that all people are able to access and gain benefits from the

health system. Improving access to general health care, including health promotion and prevention, is essential to minimising disadvantage from vulnerable subgroups like immigrant women, as supporting better integration into the health system may lead to greater health outcomes. Part of the solution to reduce barriers in access to health care for immigrants and increase its utilization will involve providing more responsive services, which includes promoting culturally friendly services and combating discrimination. The needs of immigrants, particularly women, must be given special attention and therefore specific and innovative strategies to promote communities' participation should be developed. Immigrant community's involvement in the planning and development of strategies to promote utilization of health care services may be an essential strategy to improve health outcomes for these populations and help to achieve better social integration.

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Conflict of interests

The authors declare that they have no conflict of interest.

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Table

Table 1: Socio-demographic characteristics of participants.

		Africans	Brazilians	Total
Total		20	15	35
Age (years)	21-29	2	8	10
	30-39	8	4	12
	40-45	10	3	13
Educational level (years)	≤ 6	16	-	16
	7-9	3	-	3
	10-12	1	12	13
	≥ 13	-	3	3
Immigration status	Portuguese nationality	3	1	4
	Legal status	13	9	22
	Undocumented	4	5	9
Length of stay (years)	2–5	1	11	12
	6–10	7	4	11
	11–15	3	-	3
	≥ 16	9	-	9
Employment status	Employed	18	15	33
	Unemployed	2	-	2